

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN46410			
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 3, 4, 5, and 7, 2011</p> <p>Facility number: 000978 Provider number: 15G464 AIM number: 100249370</p> <p>Surveyors: Tim Shebel, Medical Surveyor III-Team Leader Christine Colon, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/19/11 by Chris Greeney, Medical Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.</p>			W0000			
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 5 of 5 clients (clients #1, #2, #3, #4 and #5) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed.</p> <p>Findings include:</p>			W0104	<p>The Area Manager will have the dining room chairs replaced in the next 30 days. Maintenance will repair all damaged items and replace burnt out light bulbs within the next two weeks (repairs and bulb replacement</p>		10/31/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>A morning observation was conducted on 10/3/11 from 5:45 A.M. until 8:30 A.M.. Upon entering the living room of clients #1, #2, #3, #4 and #5's home, one of the dining chairs was observed to have a missing back and the seat cushion sunk in when you sat on it lifting from the wooden trim. At 6:45 A.M., client #2 was observed sitting on a second dining chair which was observed to have a sunk in seat cushion lifting from the wood trim. The bathroom was observed to have 4 blown light bulbs above the bathroom sink. The toilet paper roll was observed on the bathroom sink. There was no toilet paper holder in the bathroom.</p> <p>An interview with Direct Support Professionals (DSP) #1 and #2 was conducted on 10/3/11 at 6:05 A.M. and 7:45 A.M.. DSP #2 indicated the dining chairs have been broken since she started working there over 4 months. DSP #1 indicated there was no toilet paper holder in the bathroom.</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/3/11 at 7:40 A.M.. The SC indicated the dining chairs needed repair, there should be a toilet paper holder in the bathroom, and the light bulbs needed changing. The SC further indicated there were no maintenance repair request forms</p>				<p>completed on 10/10/11). DSPs will be retrained on proper reporting for all maintenance issues and damaged items. The maintenance department will complete all reports for repairs in a timely manner. (10/31/11). To ensure future compliance Area Manager, Property Maintenance Director, maintenance department staff, and/or Service Coordinator will monitor the house for maintenance issues bi-monthly for two months and at least monthly thereafter.</p>		

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W0112	<p>for this group home. No further documentation was available for review to indicate when the repairs would be completed.</p> <p>9-3-1(a)</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation and interview, the facility failed for 5 of 5 clients who resided in the home (clients #1, #2, #3, #4 and #5) to keep client information confidential.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/3/11 from 5:45 A.M. until 8:30 A.M.. During the entire observation a box filled with clients #1, #2, #3, #4 and #5's September 2011 used medication cards sat on the fireplace mantle in the open television room area. The clients' names, medication names, and dosage information were observed.</p> <p>An interview with the Service Coordinator (SC) was conducted on</p>			W0112	<p>The Community Services Nurse will retrain DSPs on proper storage of all medication containers. (10/31/11). To ensure future compliance the Community Services Nurse and/or Service Coordinator will monitor the medication storage bi-monthly for two months and at least monthly thereafter.</p>		10/31/2011

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W0140	<p>10/3/11 at 7:30 A.M.. The SC indicated the facility was in the process developing a system to keep the old medication cards until they were taken to the facility's administrative office.</p> <p>9-3-1(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, the facility failed to maintain an accurate accounting system for 4 of 5 clients living at the group home (clients #1, #3, #4 and #5), for whom the facility managed their personal funds accounts.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the group home on 10/3/11 at 6:10 A.M.. A review of client #1, #3, #4 and #5's financial records indicated the following:</p> <p>Accounting ledger dated 9/16/11 to 9/29/11 indicated a balance of \$66.90 for client #1's personal finances. Direct Support Professional (DSP) #1 reviewed</p>			W0140	<p>The Service Coordinator will retrain DSPs on accurate and timely completion of all client budgets and finances. (10/31/11). To ensure future compliance the Service Coordinator will review all client budgets and finances weekly for one month and bi-weekly thereafter.</p>		10/31/2011

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	<p>the currency in client #1's petty cash pouch and counted a balance of \$33.86.</p> <p>Accounting ledger dated 9/30/11 indicated a balance of \$19.54 for client #3's personal finances. Direct Support Professional (DSP) #1 reviewed the currency in client #3's petty cash pouch and counted a balance of \$19.53.</p> <p>Accounting ledger dated 9/30/11 indicated a balance of \$33.22 for client #4's personal finances. Direct Support Professional (DSP) #1 reviewed the currency in client #4's petty cash pouch and counted a balance of \$33.16.</p> <p>Accounting ledger dated 9/30/11 indicated a balance of \$43.53 for client #5's personal finances. Direct Support Professional (DSP) #1 reviewed the currency in client #5's petty cash pouch and counted a balance of \$28.53.</p> <p>An interview with DSP #1 was conducted at the group home on 10/3/11 at 6:25 A.M.. DSP #1 indicated the the facility managed each clients' finances and further indicated the documented balances should match what is available in each clients personal financial pouch. DSP #1 further indicated the balances did not match the amounts in each clients personal finance pouch.</p>						

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W0249	<p>An interview with the Service Coordinator (SC) was conducted on 10/3/10 at 6:30 A.M.. The SC indicated the financial records balance sheets should match the amounts in each clients' personal funds pouch.</p> <p>9-3-2(a)</p>		W0249	<p>The Service Coordinator will retrain DSPs on implementation and documentation of client objectives/ISPs. (10/31/11). To ensure future compliance the Service Coordinator will monitor active treatment and ISP implementation weekly for one month and at least bi-monthly thereafter.</p>		10/31/2011	
	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed to implement active treatment objectives for 3 of 3 sampled clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>A morning observation was conducted on 10/3/11 from 5:45 A.M. until 8:30 A.M.. During the observation, DSP #1 and #2 were not observed to prompt client #1 to identify pictures on a communication board and DSP #1 and #2 were not observed to prompt or assist client #2 in using a communication book to</p>						

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	<p>communicate with her. During the observation client #3 was not observed utilizing a communication book, nor were DSP #1 and #2 were not observed using a communication book to communicate with her.</p> <p>A review of client # 1's record was conducted on 10/4/11 at 9:10 A.M.. A review of client #1's Individualized Support Plan (ISP) dated 1/14/11 indicated: "Communication: Will improve her communication skills by learning to identify pictures, when asked to so...[Client #1] will identify several pictures on her board."</p> <p>A review of client # 2's record was conducted on 10/4/11 at 10:54 A.M.. A review of client #2's ISP dated 1/27/11 indicated: "Will learn to use a communication (picture) book daily."</p> <p>A review of client # 3's record was conducted on 10/4/11 at 11:30 A.M.. A review of client #3's ISP dated 6/9/11 indicated: "Will continue to utilize her communication book by pointing to pictures of wants daily to increase her communication skills."</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/10 at 12:13 P.M.. The Service</p>						

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W0369	<p>Coordinator indicated DSP staff are trained in each clients' active treatment goals and BSPs and should implement them at all times of opportunity.</p> <p>9-3-4(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 clients observed during medication administration (client #4) to ensure staff administered the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/3/11 from 5:45 A.M. until 8:30 A.M.. At 8:25 A.M., client #4 was observed receiving her Nabumetone 750 mg (milligram) tablet for body fluid retention with no water. At 8:28 A.M., a review of the medication punch card and Medication Administration Record dated 10/11 indicated: "Nabumetone 750 mg tablet...1 tablet orally two times a day...with plenty</p>		W0369	<p>The Community Services Nurse will retrain DSPs on proper medication pass to ensure clients are offered fluids with their medications and to ensure the client's needs are met with medication pass. (10/31/11). To ensure future compliance the Community Services Nurse and/or Service Coordinator will observe medication pass bi-monthly for one month and at least monthly thereafter.</p>		10/31/2011	

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W0391	<p>of water."</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 10/3/11 at 8:30 A.M.. DSP #1 indicated client #4 did not drink water with her medications.</p> <p>An interview with the facility's Licensed Practical Nurse (LPN) was conducted at the facility's administrative office on 10/4/11 at 12:15 P.M.. The LPN indicated client #4 should have received at least 8 ounces of water with her medication. The LPN further indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 3 of 10 medications administered to 1 of 3 sampled clients (client #3), the facility failed to remove from use the medication containers with worn/torn labels and without labels on the medication.</p>			W0391	<p>Community Services Nurse will retrain DSPs on proper labeling of medication, reporting and replacing worn or missing labels on all medications. (10/31/11)</p> <p>To ensure future compliance the Community Services nurse and or Service Coordinator will check labels at least bi-monthly for sixty days and at least monthly thereafter.</p>		10/31/2011

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	<p>Findings include:</p> <p>A morning observation was conducted on 10/3/11 from 5:45 A.M. until 8:30 A.M.. At 7:50 A.M., client #3 was observed during medication administration was completed with Direct Support Professional (DSP) #1. DSP #1 selected client #3's unlabeled lip balm inside an unlabeled bag, and applied it on client #3's lips. Review of the lip balm and Medication Administration Record (MAR) dated 10/1/11 indicated: "Vaseline Lip Therapy...apply to lower lip two times a day...dry lips." DSP #1 was observed to take a bottle with a worn label out of the unlabeled bag and administered the syrup. Review of the bottle and MAR indicated: "Calciferol liquid...give 2 drops in water 3 times a day...supplement." DSP #1 was observed to take a bottle with a torn label out of the unlabeled bag. Review of the bottle and MAR indicated: "Loratidine syrup 5 mg...give 10 ml (milliliters) orally once a day."</p> <p>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 10/4/11 at 12:15 P.M.. The LPN indicated all medications are to have a label and further indicated the labels are not to be worn or torn.</p>						

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W0440	<p>9-3-6(a)</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview the facility failed to hold evacuation drills on the evening and overnight shifts (evening-3:00 P.M. to 11:30 P.M., and overnight-11:30 P.M. to 6:30 A.M.) during the fourth quarter of 2010 for 5 of 5 clients living at the group home (clients #1, #2, #3, #4, and #5).</p> <p>Findings include:</p> <p>The facility records were reviewed on 10/3/11 at 3:13 P.M.. Review of the facility's evacuation drills, from 10/1/10 to 10/3/11 failed to indicate evacuation drills were held for clients #1, #2, #3, #4, and #5 during the evening and overnight shifts during the fourth quarter of 2010. The last overnight shift drill was held on evening shift was held during the 3rd quarter on 7/12/10 and the most recent was held during the 1st quarter on 1/29/11. The last evening shift drill was held on evening shift was held during the 3rd quarter on 7/10/10 and the most recent was held during the 1st quarter on</p>		W0440	<p>The Area Manager will retrain Direct Support Professionals on the timeframes for the different shifts as required by the evacuation drills. Training is to include varying the time of the evacuation drills and making sure that the time of the drill is clearly within the shift required, paying special attention to the timeframes at the end of the third shift and the beginning of the first shift. The Area Manager will be present for the first evacuation drill after retraining to insure that all staff are informed and able to carry out the necessary evacuation drills. (10/31/11). To ensure future compliance the Area Managers will monitor evacuation drills 2x a month x 3 months, then monthly thereafter. The tracking system for monitoring evacuation drills will be revised and reviewed monthly to insure timeliness of training and drill.</p>		10/31/2011	

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	2/16/11. Service Coordinator #1 was interviewed on 10/3/11 at 3:25 P.M.. Service Coordinator #1 indicated there was no additional documentation on evacuation drills for the facility. 9-3-7(a)						